STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155567	A. BUILDING _____ B. WING _____	03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00086570. Complaint Number IN00086570, unsubstantiated due to a lack of evidence. Survey dates: February 28, March 1, 2, and 3, 2011 Facility number: 000459 Provider number: 155567 AIM number: 100289700 Survey team: Christine Fodrea, RN TC Rick Blain, RN Sue Brooker, RD Census bed type: SNF: 5 SNF/NF: 76 Total: 81 Census payor type: Medicare: 8 Medicaid: 49 Other: 24 Total: 81 Sample: 18	F0000	*This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-6-11 Cathy Emswiller RN			

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F0272 SS=D	Based on interview and record review, the facility failed to evaluate bowel continence after a change in bowel continence status for 1 of 3 residents reviewed for bowel continence in a total sample of 18. (Resident #84). Findings include: Resident #84's record was reviewed 3-2-11 at 10 a.m. Resident #84's diagnoses included, but were not limited to, diabetes, high blood pressure and stroke. Resident #84's Bowel and Bladder Assessment and Management form dated 1-16-11 indicated Resident #84 was continent of bowel, needed assistance to the bathroom, and had minor functional impact on his bowel status from health conditions; and was a possible candidate for retraining. The back of the Bowel and Bladder Assessment and Management form indicated under management program, Resident #84 was not a candidate for retraining as he was continent of bowel. A Physician's progress note dated 2-5-11 indicated Resident #84 had been recently readmitted after hospitalization with a stroke leaving his left side not moving.	F0272	*It is the policy of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.* Resident #84 was transferred on 2/11/11. Due to this, facility unable to perform corrective action with affected resident. Clinical records were reviewed for Bowel and Bladder Assessments to determine if any other resident was affected. None were found. Licensed nursing staff to be re-educated on proper documentation of Bowel and Bladder Assessments. Bowel and Bladder Template to be utilized in MAR with a 3 day voiding pattern after admission or readmission. Upon the 4th day, bowel and bladder assessment will be completed to ensure accuracy. The DON or designee to monitor Bowel and Bladder Template in MAR daily. Upon completion of Bowel and Bladder Assessment, Unit Manager will review Assessment and Template to ensure accuracy and completion. Addendum:The DON or designee to monitor Bowel and Bladder Template in MAR daily on newly admitted or readmitted residents.. Upon completion of Bowel and Bladder Assessment, Unit Manager will review Assessment and Template to ensure accuracy and completion. Quality Assurance to review results monthly x6 months or until	04/01/2011

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	Resident #84 was readmitted to the facility on 2-4-2011. His Bowel and Bladder Assessment and Management form dated 2-4-11 indicated Resident #84 was incontinent of Bowel, needed assistance to the bathroom, and had minor functional impact from his health conditions; despite his change in bowel continence. There was no indication on the back of the Bowel and Bladder Assessment and Management form under management program whether Resident #84 was a candidate for retraining. In an interview on 3-3-2011 at 10 a.m., the Regional Clinical Director indicated the facility should have completed the assessment and evaluation. A current policy titled Continence Maintenance Program dated April 2011 provided by the Administrator on 3-3-2011 at 1 p.m. indicated "...It is the facility standard to identify residents with incontinence, assess contributing factors, ...to achieve and maintain the highest functional status of continence deemed possible...1. Upon admission, evaluate the continence status and determine the appropriate level of assistance and toileting modes needed to meet elimination needs...."		pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	

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	3.1-31(c)(11)			

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F0281 SS=D	Based on interview and record review, the facility failed to ensure communication with other members of the nursing team with regard to medication administration for 1 of 15 residents reviewed for medication administration in a total sample of 18. (Resident #24) Findings include: Resident #24's record was reviewed 2/28/11 at 1 p.m. Resident #24's diagnoses included, but were not limited to, depression, anemia, and osteoporosis. A physician's order dated 2/25/11 indicated to start Enablex 7.5 mg to be given every day for overactive bladder. A Medication Administration Record dated February 2011 indicated Enablex had been started 2/27. There was no signature indicating the medication had been given on 2/28. The Medication Administration Record dated March 2011 did not list Enablex as a medication that was to be given. A review of the current physician's orders did not indicate the medication Enablex had been discontinued.	F0281	*It is the policy of the facility that services provided or arranged by the facility must meet professional stands of quality..* Resident #24 physician orders reviewed by DON. Transcription Error report written by LPN #1 and DON for Enablex error. LPN #1 noted Enablex into March MAR. Attending physician and Resident #24 notified of error. DON or designee to perform facility wide review of all residents' MARs to ensure accuracy with physician orders. Licensed nursing staff re-educated on proper Medication Administration and Monthly Re-write of MARs protocol. Unit Managers will review 50% of residents' MARS upon completion of monthly re-writes for 3 months. Unit Managers to report findings to DON. DON or designee to perform random reviews of re-writes for 6 months of residents' MARs. Quality Assurance Committee to monitor for 6 months. Addendum:Unit Managers to report findings to DON. DON or designee to perform random reviews of re-writes monthly for 6 months of residents' MARs. Random reviews to be 10% of residents. Quality Assurance to review results monthlly x6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated. Re-write process is as inservice	04/01/2011

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	In an interview on 3/2/2011 at 1:30 p.m. LPN #1 indicated Enablex should have been given. Additionally, medications ordered the last week of the month should be noted on the next month's Medication Administration Record by the nurse taking the order. In an interview on 3/2/2011 at 2:05 p.m. LPN #1 indicated Enablex had been given without indication for or documentation of administration on the Medication Administration Record. A copy of the Enablex medication card supplied by the Director of Nursing on 3/2/2011 indicated 16 tablets had been supplied to the facility on 2/26/2011. 4 tablets had been taken from the card. In an interview on 3/2/2011 at 2:05 p.m., LPN #1 indicated the nurse administering medications, upon finding a medication, usually given, was not listed on the Medication Administration Record, should have verified the medication was to be given, then wrote the medication on the Medication Administration record to communicate with other medication administration personnel. A current policy titled General Dose		contect that is attached. See Re-write Attachement A.	

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	Preparation and Medication Administration revised dated 5/1/2010 supplied on 3/3/2011 by the Director of Nursing indicated "... 4.1 Facility staff should:...4.1.2 Confirm that the MAR (Medication Administration Record) reflects the most recent medication order...." Indiana code 848 IAC 2-3-2 Responsibility as a member of the health team indicates "...3.) Communicate, collaborate, and function with other members of the health care team to provide safe and effective care...." 3.1-35(g)(1)			

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F0282 SS=D	Based on observation, interview and record review, the facility failed to ensure protective clothing was applied as outlined in the plan of care for 3 of 10 residents reviewed with protective clothing in a total sample of 18. (Resident # 24, Resident #26, and Resident #23) Findings include: 1. Resident #24's record was reviewed 2/28/11 at 1 p.m. Resident #24's diagnoses included, but were not limited to, depression, anemia, and osteoporosis. Physician's order sheets dated February and March 2011 indicated Knee high TED (thromboembolitic reduction device) hose were to be applied in the morning and taken off in the evening to reduce possibility of blood clots in her legs. On 2/28/2011 at 11:30 a.m., Resident #24 was observed up in her wheelchair in her room. No TED hose were on. On 3/1/2011 at 11:30 a.m., Resident #24 was observed in her room no TED hose were on. On 3/2/2011 at 6:05 a.m., Resident #24 was up in her wheelchair no TED hose were on.	F0282	*It is the policy of this facility that the services provided or arranged, be provided by qualified persons in accordance with each resident's written plan of care:* Resident #24, #26, and #23 has TARs and Careplans reviewed by DON. Protective garments applied to Resident #23. TED Hose applied to Resident #24 and #26. ADL Plan of Care updated for Resident #23. DON reviewed all residents' TARs/Careplans for protective garments and/or TED Hose required to ensure accuracy of residents' careplans. DON or designee to add necessary changes in the Vocollect ADL Plan of Care. Licensed nursing staff and CNA's to apply protective garments and TED hose per physician order and/or nursing measure. Floor nurse to verify and document in TAR that protective garments and TED hose have been applied. Random visual monitoring of residents to be performed by DON or designee. Interdisciplinary Team to update careplans according to resident needs and physician orders. Interdisciplinary Team to ensure Vocollect plan of care matches careplans upon completion of resident's IDT rounds. Quality Assurance Committee to monitor for 3 months. Addendum:Random visual monitoring of 50% of residents with protective	04/01/2011

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	In an interview 3/2/2011 at 6:05 a.m. Resident #24 indicated she no longer wore TED hose because the staff told her she did not need them. In an interview 3/2/2011 at 2:05 p.m., LPN #1 indicated Resident #24 should have TED hose on. A review of Nursing Notes for the time period of 2/28/2011 through 3/2/2011 did not indicate Resident #24 had refused to wear TED hose. 2. Resident #26's record was reviewed 3/2/2011 at 2 p.m. Resident #26's diagnoses included but were not limited to diabetes, congestive heart failure, and high blood pressure. A physician's order summary dated March 2011 indicated TED hose were to be applied every morning and taken off every evening to reduce to possibility of blood clots in her legs. On 3/2/2011 at 2;15 p.m., Resident #26 was observed in the common living area sleeping in her wheelchair. No TED hose were on. On 3/3/2011 at 8:30 a.m., Resident #26		garments and/or TED Hose to be performed by DON or designee on various shifts, including weekends. Interdisciplinary Team to update careplans according to resident needs and physician orders. Interdisciplinary Team to ensure Vocollect plan of care matches careplans upon completion of resident's IDT rounds. Quality Assurance to review results monthly x6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	

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was observed propelling herself on the 200 hall. No TED hose were on.

In an interview 3/3/2011 at 10 a.m., LPN #4 indicated Resident #26 should have her TED hose on.

3. Review of the clinical record for Resident #23 on 2/28/11 at 1:04 p.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's dementia with agitation and hitting and failure to thrive.

Current physician orders for Resident #23, dated 3/1/11, indicated geri sleeves at all times as a nursing measure with a start date of 5/20/09.

A facility Change of Condition Report - Skin Condition for Resident #23, dated 9/20/10, indicated a skin tear was found on her left forearm.

A facility Change of Condition Report - Skin Condition for Resident #23, dated 9/30/10, indicated a skin tear was noted to her right forearm. The Change of Condition Report also indicated Resident #23 was to have geri sleeves to her bilateral forearms at all times.

A facility Change of Condition Report -

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	Skin Condition for Resident #23, dated 10/14/10, indicated a skin tear was found on her right forearm. A facility care plan for Resident #23, with an initiation date of 5/20/10 and a review date of 10/29/10, indicated geri sleeves per physician orders. An Interdisciplinary Progress Note for Resident #23, dated 2/10/11, indicated her skin was intact but fragile. The Interdisciplinary Progress Note also indicated her skin was at risk secondary to a history of skin tears. The Interdisciplinary Progress Note further indicated she was to wear geri sleeves to her bilateral arms for prevention. Certified Nursing Assistants (CNA #2, CNA #3) were interviewed on 3/2/11 at 10:06 a.m. During the interview they indicated the care each resident required was programmed into the headsets they wore. They also indicated the programmed headsets would prompt them to provide the care each resident required. A current printed ADL (activities of daily living) Plan of Care for Resident #23, provided by the Administrator on 3/2/11 at 10:30 a.m., indicated all areas of care she required. The areas of care were the			

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	same as those programmed into the headsets each CNA wore. The printed ADL Plan of Care did not include the geri sleeves at all times. The Director of Operations was interviewed on 3/2/11 at 3:05 p.m. During the interview he indicated physician orders for resident care were entered into the headset system by the nursing staff. He also indicated while wearing the headsets, CNA's were able to identify the room of the resident and the system would prompt them on what care each resident required. The Regional Director of Clinical Operations was interviewed on 3/3/11 at 9:40 a.m. During the interview she indicated the facility did not have any policy on following physician orders. She also indicated it was a standard practice to follow physician orders. 3.1-35(g)(2)			

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F0514 SS=D	Based on interview and record review, the facility failed to ensure accurate documentation regarding medications for 1 of 15 residents reviewed for medication administration documentation in a total sample of 18. (Resident #24) Findings include: Resident #24's record was reviewed 2/28/11 at 1 p.m. Resident #24's diagnoses included, but were not limited to, depression, anemia, and osteoporosis. A.) A physician's order dated 2/25/11 indicated to start Enablex 7.5 mg to be given every day for overactive bladder. A Medication Administration Record dated February 2011 indicated Enablex had been started 2/27. There was no signature indicating the medication had been given on 2/28. The Medication Administration Record dated March 2011 did not list Enablex as a medication that was to be given. A review of the current physician's orders did not indicate the medication Enablex had been discontinued. In an interview on 3/2/2011 at 1:30 p.m.	F0514	It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Resident #24 physician orders reviewed by DON. Transcription Error Report written by DON for Enablex and Ferrex. Enablex noted in March MAR. Attending physician and Resident #24 notified of transcription error. DON or designee to perform facility wide review of all residents' MARs to ensure accuracy with physician orders. Licensed nursing staff re-educated on proper Medication Administration and Monthly Re-write of MARs protocol. Unit Managers will review 50% of residents' MARS upon completion of monthly re-writes for 3 months. Unit Managers to report findings to DON. DON or designee to perform random reviews of re-writes for 6 months of residents' MARs. Quality Assurance to review results for 6 months or until pattern of consistent compliance achieved with a subsequent plan developed and implemented as indicated.	04/01/2011

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	LPN #1 indicated Enablex should have been given. Additionally, medications ordered the last week of the month should be noted on the next month's Medication Administration Record by the nurse taking the order. In an interview on 3/2/2011 at 2:05 p.m. LPN #1 indicated Enablex had been given without documentation of administration on the Medication Administration Record. A copy of the Enablex medication card supplied by the Director of Nursing on 3/2/2011 indicated 16 tablets had been supplied to the facility on 2/26/2011. 4 tablets had been taken from the card. B.) A physician's order dated 1/17/2011 indicated Ferrex 150 mg was to be given twice daily for 30 days to Resident #24. Resident #24's Medication Administration Record dated February 2011 indicated Ferrex had been given twice daily 2/17 through 2/28, despite the automatic stop date of 2/16/2011. In an interview on 3/3/2011 at 9:10 a.m., the Director of Nursing indicated Ferrex should not have been given past 2/16/2011.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	1400 MEDICAL PARK DRIVE FORT WAYNE, IN46825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 3/3/2011 at 10:05 a.m., the Director of nursing indicated Ferrex had not been given past 2/16/2011 as the medication was not available. Additionally, the nurse administering medications 2/17 through 2/28/2011 should not have documented the Ferrex had been given. On 3/3/2011 at 10:05 a.m., a proof of delivery document was provided by the Director of Nursing indicated Resident #24 had been supplied Ferrex on 1-17-2011 numbering 60 limiting availability of the medication after 2/16/2011. A policy entitled General Dose Preparation and Medication Administration revised 5/1/2010 provided by the Director of Nursing on 3-3-2011 at 10:05 a.m. indicated "...6. After medication administration...document necessary medication administration...on appropriate forms...." 3.1-50(a)(2)			